

# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

|   |  |
|---|--|
| <b>Type of Requestor:</b> (x) HCP ( ) IE ( ) IC                                       | <b>Response Timely Filed?</b> (x) Yes ( ) No |
| Requestor's Name and Address<br>Dr. B<br>7125 Marvin D. Love #107<br>Dallas, TX 75237 | MDR Tracking No.: M4-04-3607-01              |
|   | TWCC No.: _____                              |
|   | Injured Employee's Name: _____               |
| Respondent's Name and Address<br>Texas Mutual Insurance Co.<br>Box 54                 | Date of Injury: _____                        |
|   | Employer's Name: _____                       |
|   | Insurance Carrier's No.: 99C0000322434       |

## PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

| Dates of Service |          | CPT Code(s) or Description | Amount in Dispute | Amount Due |
|------------------|----------|----------------------------|-------------------|------------|
| From             | To       |                            |                   |            |
| 11/14/02         | 04/14/03 | 99070-73                   | \$30.00           |            |
|                  |          |                            |                   |            |
|                  |          |                            |                   |            |
|                  |          |                            |                   |            |

## PART III: REQUESTOR'S POSITION SUMMARY

Position Statement dated 11/10/03 states in part, "...Our charges were denied as F; Fee schedule. We had submitted our bills back in for reconsideration and again denied. Carrier states that our TWCC-73 Patient Status Forms are not correctly filled out. Our forms are completely filled out according to TWCC Rule 129.5: Work Status Reports..."

## PART IV: RESPONDENT'S POSITION SUMMARY

Position Statement dated 11/26/03 states in part, "...This carrier did not request additional TWCC 73 per TWCC Rule 129.5(d)(3) and the requester did not document a change in the employee's work status... This employee was UNABLE to work on 10/17/02. The employee remained UNABLE to work on the dates of service in dispute and beyond. There was NOT a significant change in the employee's work status or activity restrictions... Therefore, no reimbursement was due for the 11/14/02 and 04/14/03 charges in dispute..."

## PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

CPT Code 99080-73 for dates of service 11/14/02 and 04/14/03 denied as "F, TD – The work status report (TWCC-73) was not properly completed or was submitted in excess of the filing requirements...". The insurance carrier submitted original EOB denying the services as "F". Per Rule 129.5 the requestor did not show a change in the employees work status or a substantial change in activity restrictions; therefore, reimbursement is not recommended.

**PART VI: DETAIL FINDINGS (If needed)**

| Date of Service | CPT Code | Amount in Dispute | Amount Due | Date of Service    | CPT Code | Amount in Dispute | Amount Due |
|-----------------|----------|-------------------|------------|--------------------|----------|-------------------|------------|
| 11/14/2002      |          |                   |            |                    |          |                   |            |
| 4/14/2003       | 99080-73 | \$30.00           | \$0.00     |                    |          |                   |            |
|                 |          |                   |            |                    |          |                   |            |
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|                 |          |                   |            |                    |          |                   |            |
|                 |          |                   |            |                    |          |                   |            |
|                 |          |                   |            | Total Left Column: |          |                   | \$30.00    |
|                 |          |                   |            | Total Amount Due:  |          |                   | \$0.00     |

**PART VII: COMMISSION DECISION AND ORDER**

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to reimbursement.

|             |                   |          |
|-------------|-------------------|----------|
| Ordered by: | Marguerite Foster | 12/17/04 |
|-------------|-------------------|----------|

|                      |            |               |
|----------------------|------------|---------------|
| Authorized Signature | Typed Name | Date of Order |
|----------------------|------------|---------------|

## PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on \_\_\_\_\_. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

**Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**

**PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION**

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: \_\_\_\_\_ Date: \_\_\_\_\_